J. W. Good, The Most Unforgettable Character I Have Known

by E. W. Montgomery, M.D.

I first heard of Dr. Good when I was going to Normal School in 1887, when the principal of the Normal School was advising me as to my subsequent career, and he quoted Dr. Good as being the most prominent and prosperous gentleman of the profession in Winnipeg at that time. I immediately became interested in Dr. Good and the practice of medicine and I entered Medical College the next year. During my course in Medical College I had many opportunities of observing the Doctor.

Physically he was a man most attractive in appearance, tall and broad-shouldered, his hair was black and wavy, he had brown eyes and according to the customs of that remote period he had a luxuriant mustache. He was always well-dressed. He seemed to be in a hurry as though his office was full of patients waiting for him, which was undoubtedly the case.

I remember the first clinic of his which I attended. A rural gentleman came into the hospital with a felon on his finger that had been neglected until the bone was exposed and the inflammation had spread up the infected finger into the palm of the hand. The Doctor held the patient's arm up till everyone in the class could see the bare bone and the purulent tissues around it. "This, gentlemen," he said, "is how nature effects a cure." About that time he gave up general practice and was the first specialist in Winnipeg; treating exclusively diseases of the eye, ear, nose and throat.

He was born in Kincardine, Ontario, and attended Public School there, subsequently getting his medical degree in Toronto, and after graduating taking a short post-graduate course in England. He set up practice in the city of Winnipeg about 1880. While at the Public School in Kincardine I understand that his attendance was not regular, but he was always there when the roll was called, and doubtless emulated Tom Sawyer and achieved a high standing at the end of each term.

The Klondike

He never could keep his school books, losing them on the way to or from school, and his sense of order and neatness was primitive, or at least undeveloped, and during his long life he never achieved a systematic or orderly way of living. He travelled a great deal; on leaving the city his luggage would consist of numerous grips, suitcases, etcetera, but when he returned he would have but one bag and probably one clean collar and a couple of soiled handkerchiefs; everything else had disappeared along the way. I remember quite well when he went on a pilgrimage to the Klondike in '98 or '99. He left Winnipeg with a marvellous Sea Otter coat that had cost him about $2,000. When he came back two years later he had a lumberjack's outfit, well worn at that, and nothing else in the way of clothing. His career in the Klondike was an epic, and should have been the subject of a poem by Robert Service, the author of "The Lady Called Lou." He was made first health officer of Dawson City, which entailed crossing the Yukon River frequently in a canoe, and before crossing he always put on a life preserver, and on one occasion that saved his life. That sojourn in the Klondike was the source of many romantic and intriguing stories of life in the raw. We were all glad to have him back, as he had been the Dean of the Faculty before going north. When asked what rewards he had gained by his Klondike trip he replied, "Only culture."

His most productive years were those which lay between 1902, when he returned from the Klondike, and 1920, when he left Manitoba to reside in Vancouver. His success and his financial prosperity was largely due to the fact that he had acquired the services of Miss K., a trained nurse, who looked after his business and managed the details of his office with a master hand. His investments during that period were large and profitable, and he was able to retire in 1920 with an ample competence. Up till the time he went to the Klondike his business was managed in such a haphazard way that he had never learned how to save—only to spend. But gradually under the tutelage of Miss K. he gained an increasing interest in his bank balance, in fact I remember him saying when he had reached the age of seventy that he had sloughed off all of his vices save one, namely, avarice. Among other habits which he acquired during this period of his life was that of being extremely fastidious in his dress, wearing a morning-coat and a plug hat, on Sunday, always. I remember well on one occasion when there was a Methodist Conference in the city. It was a bright morning in June and it happened that two or or three persons in clerical garb were going up in the elevator in the McIntyre Block when Dr. Good entered. I think on that occasion he wore a white tie because one of these visiting firemen remarked to the Doctor, "It is a beautiful morning is it not, brother?" and the Doctor replied immediately "You bet your God-damned life it is!" He had a very apt habit of nicknaming all eccentric individuals with whom he came in contact. The elevator boy in the McIntyre Block was one of those fat, somnolent individuals and Dr. Good had christened him "Guts." The name of "Guts" stuck to him as long as he was on the job.

Amateur Bartender

Let us turn to the festive period in the annals of Winnipeg, "When our hearts were young and gay," dating from 1885 to 1898 when he went to the Klondike. The Doctor was then en-

dowed with the exuberance of youth, a magnificent physique, a scintillating wit and a keen and curious mind. The atmosphere of this city at that time, beside being cold in winter and hot in summer, as it still is, was supercharged with business activities. The real estate boom was on, there was easy money for everyone, and besides there were rather ill-defined standards of social behavior. All the hotels were equipped with bar-rooms that overshadowed the kitchens and sleeping accommodation. The bartenders were gorgeous, and the business of dispensing cocktails and whiskey straight was amazingly profitable and attractive.

One of the most flamboyant of the gin palaces of that time was known as the Board of Trade Saloon. It was located on the site of the present Great West Life Building, on Lombard Street. The building was old, and the ground floor was entirely occupied by a bar-room at one end of the main floor and a vaudeville stage at the other. All the elite of the male population freely patronized both ends of the show. One afternoon which could never be forgotten by those of us who were in Winnipeg at that time, Dr. Good rented the Board of Trade Saloon for the rest of the day. He went into the enterprise in the rôle of Business Manager and Bartender, assuming the uniform of the regular dispenser behind the ornate bar; white apron, immaculate shirt-front and waistcoat and a well-trimmed handlebar mustache. In a few moments it got to be known throughout the business district that Dr. Good was in charge, and before long there was standing room only at the Board of Trade, and the rush continued until dawn of the following day. A fitting climax to a day of pure joy for all concerned. Even yet, after more than fifty years some of the old-timers remember that hectic performance.

Speaking of hotels and bar-rooms reminds me of another episode in the Doctor's life that occurred a little later than the Board of Trade incident. Deer Lodge Hotel, which stood where the Deer Lodge Hospital now stands was a picturesque old wooden structure, and its equipment throughout was no less picturesque than the building itself. The proprietor was familiarly known as "Chad." In addition, the presiding genius in the bar was quite a celebrated character whose first name was "Jimmie." He was always clean-shaven and had a clerical appearance when at work. He hardly ever spoke except to answer a question, his voice was low and soft, and his gestures were equally deliberate and graceful. An additional attraction to the institution was a tame bear, commonly known as "Chad's bear." This was a huge monster and was said to weigh at least fifteen hundred pounds. The custom was for many years during the career of "Chad's bear" for everyone who visited the institution to buy ginger beer or other soft drinks for the bear. The bear stood erect, took the bottle in his paw, and drank the contents, probably a hundred bottles or more of pop during the day. In fact he consumed so much of the sweet liquids there was a constant stream of wagons hauling the stuff out from a factory in the city. It must have been this enormous quantity of sweet pop that caused the bear to assume such tremendous proportions. It was a profitable business for both the bear and the pop dealers, as almost everyone who went to the hotel for any purpose bought pop for the bear.

It is evident therefore that Deer Lodge Hotel was a most attractive suburban resort and thither on many occasions Dr. Good went on a retreat. Once I remember quite well that "Chad" telephoned Dr. Bell. At the time I happened to be in Dr. Bell's office and I heard Dr. Bell's end of the conversation, and it went like this: "Yes, what did you say Chad? Dr. Good is out there, yes, what did you say? Humph!" I said "What is it?" "Yes, he's out there and Chad says he is sleeping in every bed in the house, and for heaven's sake come and get him home," which we proceeded to do with the assistance of Dublin Dan, a hack-driver who was deeply interested in the Doctor's welfare. This was long before Portage road was paved and the mud that spring day was impassable, almost, as it took several hours to make the trip from the city to Deer Lodge and back. The business of hotel-keeping at present appears to have lost most of its glamor in comparison with what happened in the good old days before '98.

The Smoking Dean

During the long period when he was Dean of the Medical School, previous to '98 and the Klondike Rush, all the meetings of the Faculty were held in his office in the old Dundee Block, where the present C.N.R. ticket office is located. I attended most of these meetings and certainly they were colorful. The Dean sat in his usual place behind the desk and the rest of the Faculty sat on occasional chairs, couches, window-sills, etcetera. When the meeting began the Dean assumed the look with which the General Manager of—let us say—the Bank of Canada, opens its annual meeting: businesslike, stern, merciless, pitiless to the point of savagery. Everyone started to smoke, the presiding genius lit up first; he smoked cigars in a manner characteristic of the man; he smoked one end of the cigar and ate the other, the opposing forces met in about two minutes; then he lit another! By this time smoke was so thick and everyone so mellow and joyous and forgiving that we decided there wasn't a quorum and after a couple of hours the meeting adjourned. Once I can remember quite well he asked the Professor of Anatomy, Dr. Neilson, to go down to Erzinger's store and get him 50 cents' worth of cigars. Neilson smiled a sickly kind of smile and did as he was told, to the great amusement of all present. Business was always transacted in a hurry, and if any student was delinquent in his fees the Dean agreed to discharge him immediately. But he always saw to it that the fee was paid the next day and no one was ever discharged.

Dr. Good never bought cigars by the box, and why? Because in the first place he was always trying to swear off smoking, and if he had a box of cigars handy the temptation was more than he could stand, so he thought; but, as there was the largest cigar store in town at the foot of the stairs he put up a poor fight. The second reason was that if he had a box of cigars on the table at a Faculty meeting, the box would be empty when the meeting was over. He wasn't niggardly, but there was nothing that he enjoyed more than to smoke a fat cigar himself and to see everyone else sitting around envying him.

Dawn Patrol

Dr. Good travelled a great deal; his sojourn in the Yukon seemed to kindle his desire to browse in fresh fields and pastures new. One winter he spent in Vienna and brought to Winnipeg some of the quaint and curious customs of that metropolis. It appears that many of the surgeons of Vienna were in the habit of operating only in the morning, and beginning sharp at seven. Shortly after his return one morning he got up before six, went to the Manitoba Club for breakfast before the cook arrived, and got to St. Boniface Hospital on the dot of seven a.m. to find no one on duty but the night-watchman, and the operating theatre locked up; finally he got an interview with the Sister Superior and from that interview he came away a wiser man. (Bell afterward gave me Good's story of the seance); Good said: "For one who travels life's thorny path in the guise of humility and self-sacrifice, she seemed to be a trifle hard-boiled. When I told her my story she led off by saying that in Montreal where she was born, brought up, and received her training, no one ever got up before the milkman came, and he never came before nine. Then she went on to express her interest in the fact that the Austrians were going in for Daylight Saving in a big way, but she was still in doubt about whether St. Boniface Hospital should be made a Guinea Pig for the rest of North America. He said she went on in this strain—you know how women talk—just endless repetition of self-evident facts, with an occasional sugar-coated lie slipped quietly till he—Good—was forced to retreat in disorder. There was only one gleam of hope left; her last and lamest excuse was that there was no hot water to be had in the Hospital at seven a.m. Good and Bell were an unbeatable pair; the next morning they appeared at the Hospital at seven sharp, and with them were four pails of hot water that had been boiled in Winnipeg! I never heard the sequel, but I can vouch for the truth of this narrative because I saw the empty pails standing around Dr. Good's office for a week afterwards.

Office Boys

In those primitive days of the doctors who had offices on Main Street they employed neither nurse nor stenographer, but instead had what was known as "office-boys." These were very carefully selected from youths who had been expelled from public schools for conduct unbecoming to gentlemen. I met a good many of them during my association with Drs. Good and Bell, Dr. Simpson, Dr. Crawford and Dr. McCalman. The term of service with medical men in their offices did not add much lustre to the careers of these boys. Two of them studied medicine and one of them subsequently became a member of Parliament but they still trod the primrose path. Every once in a while I see the names of some of them who have now passed the meridian of life and their names are usually recorded in the proceedings of the Police Court. I suppose most of them when they entered the doctors' offices had aspired to become disciples of the healing art, but in a very short time these aspirations wilted. I remember one in particular who worked for Dr. Crawford and myself; he was fired summarily and some time later I looked under the pillow of the couch in the waiting-room, and there was his diary, and as he had already sunk into the maelstrom of business leaving no trace, I took the liberty of reading snatches of the diary. For a month before he left us, the record was the same. It was this sentence: "I pray to God every day that I may find a new job." It was the first time that I learned he was so devout. All this is introductory to a note that I have made regarding one of Dr. Good's valets. This was a young man named "Arthur." He was a dreamy, indolent sort of chap. At that time a hypnotist named McEwen was holding performances every night in a theatre just a block away from Dr. Good's office. Arthur, who attended regularly, proved to be a good subject to demonstrate the effects of hypnotism and McEwen had him up on the platform often. Finally Arthur himself tried hypnotizing his family, and was so successful that he decided to take to the road and give demonstrations of his hypnotic power, as a means of livelihood. Two or three years later he hypnotized a susceptible individual, I think it was in Jersey City, he made the subject lie down with his feet on the back of one chair and his head on the back of another, and the gentleman became so rigid that he didn't even sag in the middle. To demonstrate how rigid he was Arthur laid him on the floor and stood on his abdomen. A couple of days later the hypnotized gent became rigid with rigor mortis, and Arthur went to jail, where he may be yet, as far as I know.

Hobbies and Horses

During that long period of twenty years Dr. Good prospered and found time besides looking after his professional duties to enjoy many extraneous pursuits, of which I might describe several. Like all the other doctors in this city his means of transportation was a horse and buggy, and I remember well on one occasion that his horse became so lame and old, the stableman advised him to get a new one. Dr. Jones, who had been his partner when he first arrived in the city took Dr. Good's old horse, painted one leg white, cleaned the horse's mane and tail, blackened the hoofs, had him thoroughly cleaned up,

and sold Dean his own horse at about three times what it was worth.

During the pre-Klondike era of the Doctor's life, when he was bursting with energy and impelled by curiosity to try everything—at least once—many of us who were on the side-lines followed him in amazement and, with more than a little anxiety. We looked on him in much the same way as the spectators did when Blondin crossed the Niagara gorge on a tight-rope. A single misstep would have put a period to his career.

At that time his primary urge was to excel in athletic pursuits, chiefly boxing and horse-back riding. He was not a "natural" in the manly art, so he proceeded to hire an ex-prize fighter to coach him. The prize fighter had more than a local reputation, but he had retired from active service on account of age and overweight; nevertheless, after a month or so of training he still had more punch than the doctor. Dr. Good would never resist a good opening of any sort and one day he caught his mentor off-guard, and dealt him one on the point of the chin that sent him to the mat, but didn't prevent him from getting up instantly, and, with a wild gleam in his eye he paid the Doctor what he thought he owed him, and gave him a bonus that sent the Doctor to the mat and terminated his career in the arena. It also prevented him practicing for a week.

His flair for horse-back riding resulted from a visit to the stampede at Calgary, and he came home filled with a vision of himself as a centaur —a romantic figure, half man and half horse. Then he got a single footer, a pigskin saddle, and a complete outfit in the way of clothes, boots, etcetera, and proceeded to perfect his style by taking long rides in the early morning. For a while he did well, however, eating his meals off the mantle-piece. But a couple of tumbles demonstrated to his satisfaction that he was not a "natural" in the line of horsemanship.

Dr. Gordon Bell

About the same period when the Board of Trade incident occurred Dr. Good took as a partner a man who became as well known and beloved as Dr. Good was himself. I refer to Dr. Gordon Bell, whose history was recorded in larger letters with more enduring fame than any other man or doctor in the city. Dr. Bell had a very beneficent influence on his somewhat wayward partner and it was a great loss to Dr. Good when Dr. Bell gave up practice to become Provincial Bacteriologist and Professor of Bacteriology, but as long as the two were alive Good and Bell were associated most intimately in work and play, and in the thoughts and commendation of all who knew them. These two men differed greatly in appearance, in training, in living habits, but they had in common one outstanding quality. They had a compassionate attitude towards all the failings of ordinary men. They were uncritical; they were more than that, they loved the transgressor, and they saw in him an example of what might have been their own shortcomings. Each one of them might have said as John Bunyan did when he saw a man marching to the scaffold: "There—but for the grace of God—goes Good, or Bell."

Sky Ride

One episode in his trek to Dawson City is well remembered and worthy of mention. He went up the coast by steamboat to Skagway, Alaska, where the old trail to the Land of Gold led over Chilkoot Pass. The climb up the coast range at the point was extremely difficult, and Dr. Good was never particularly fond of exercise. He never went for walks for the walking sake. There was a cable-way which carried freight from the dock at Skagway to the top of the Pass; so the Doctor went by freight in a basket in comfort; he said he only looked over the edge once, but he perspired the rest of the way, although it was mid-winter. He never told very much about his trip in and out of Dawson City. In fact, he never told much about the countries through which he passed on his many trips abroad. But what he did remember and what did inspire him was the people that he met on the journey.

Dr. Good left no record of his unusual literary talents; even the occasional letters which he wrote were rather commonplace. He either did not, or could not, write as he talked; perhaps his explosive wit needed a listening audience to release the spark? Perhaps after all he remembered best what a Hebrew prophet said of laughter: "Even in laughter the heart is sorrowful; and the end of mirth is heaviness."

Not long ago "Information Please" asked the question "What makes life worth living?" The prize-winning answer was: To be born with the gift of laughter and a sense that the world is mad. . . It seems more than probable that Dr. Good lived according to this formula.

Wit

I believe that ninety per cent of our citizens who still remember Dr. Good remember him because of his original wit; it was spontaneous, like a perennial spring it flowed through all his conversation; it was too light and ephemeral to be recorded, but like a lightning-flash it revealed his thought. To illustrate: one day a countryman brought his wife to see the Doctor about a rapid growing lump in her throat, at a glance he saw the growth was malignant, and hopeless. The farmer said: "Doctor, can you cure her?" Like a flash came the answer: "I spell my name with two O's!"

He was born with the gift of laughter and as he passed along the road he spread it with a generous hand; one day an old lady from Portage sought an interview with the renowned Dr. Good; she was shown in and said: "Are you Dr. Good?" He replied: "Yes, I've never had to deny it yet." She said: "My, I thought you were a

much older man; you treated me twenty years ago." "Oh," he replied, "that was a dissipated and ignorant old devil who claimed to be my uncle, and I've been living down his blunders ever since I came here!"

Dr. Good's mirth-provoking remarks had commonly that quality of speech which surprises and charms by its unexpectedness; but in addition to his ever-ready wit he was a humorist of equal brilliance and renown. When present he always spoke at Student Banquets and was cheered to the echo; on such occasions he dwelt largely on the mishaps of his own early life, not on the mistakes of Moses or his neighbors; he was critical of himself alone, and held up to ridicule none other than himself. How surely did this reveal the kindly nature of the man.

His favorite prose writer was Mark Twain, and on Kipling's poems and ballads he ruminated like a clean beast. Many of the Barrack Room Ballads he had memorized, and he had also an extensive repertoire of Mark Twain's doggerel poems such as "He done his level best" and "Put your trust in Dollinger and he will see you through." He seemed to be saturated with the spirit of the world's greatest humorist and it oozed out of him not by spells but in a constant stream. The only time I ever saw him when he was not in a bantering mood was when he slept.

After reviewing this hasty sketch of a few, a mere sprinkling of ordinary happenings in the life of Dr. Good I certainly do not want to leave you with the impression that his career as a Doctor of Medicine is not worthy of record. For eight years he was Dean of this school, his private practice was the largest and most lucrative in the city, and in many of the business activities of this prosperous community he bore a large part.

May I interject a personal note? I started practice here exactly fifty years ago, November, '92. Then there were twenty-three doctors serving a population of 18,000. Of that twenty-three only three survive. I soon knew all the twenty-three well and had ample opportunities of "sizing up" the character and ability of each. This is how I rated J. Wilford Good: for sheer intellectual cleverness he led the field. And what of character? It can be truthfully said of Dr. Good that one cannot find the smallest part of his personal weight in a narrative of his exploits. He was benevolent alike when he was rich or poor. He was honest, his word was as good as his bond. He had a good share of the frailties of the common men but they taught him to forgive the faults of others; one knew instinctively there was something far finer in the man than anything he said or did. He died in 1926 in Vancouver. "May the earth rest on him as a downy coverlet, and his dreams be as pleasant as the life he led."

Clinical Pathological Conference with a Moral

Manitoba Medical College, August 15th, 1942

The patient, a man aged 43, was admitted to the Winnipeg General Hospital July 25th, 1942, complaining of chest pain, epigastric pain, dyspnoea and fever for one week.

Had rheumatic fever aged 5. Laid up 2 months. Since 1933 was rejected for various jobs because of heart disease, but had no dyspnoea and was able to do laboring work.

Began to have teeth extracted July 1st. July 13th began to have fever, sweats, anorexia, slight dry cough, dyspnoea, and an occasional momentary epigastric pain or breathing.

(Only positive findings are recorded.)

Examination: Sweating. Temperature 102. Basal creps. Epigastric tenderness. Suggestion of clubbing. No thrill. Apex not felt. Area cardiac dullness reaches to nipple line. Heart rate 100 regular. Systolic murmur all over precordium. B.P. 120/70. Hb. 73%, White cells 20,000, Urine negative throughout. Wasserman negative.

Treatment sulfathiozol gr. 15, 4 hourly.

July 27, 1942—Fibrillating at 140. Pulse 104, dyspnoea and some epigrastic pain at onset, liver palpable. Given morphine ¼. Given quinidine gr. 2½, then gr. 5 hourly for 3 doses. Normal rhythm returned after last dose. Electrocardiograph showed elevation ST_1 and ST_2.

July 30, 1942 — Aortic diastolic murmur heard. B.P. 130/60.

July 31, 1942-August 4, 1942: Daily attack of fibrillation controlled by quinidine gr. x, p.r. n, but not by gr. v, t.i.d. Sulfadiazine substituted for sulfathiozol.

August 5, 1942—Fibrillation attacks so frequent quinidine stopped and digitalis given gr. 8, followed in 6 hours by gr. 2 and next morning by gr. 4.

August 6, 1942—At 6 p.m. heart rate 100 fibrillating. Patient reading paper and wishing to get up.

10 p.m.—Sudden attack extreme dyspnoea, cold, sweating cyanosed. Heart rate 160 irregular. Given morphine. Heart rate became more rapid and pulse imperceptible. Cheyne-Stokes breathing was followed by a few dying gasps and patient expired at 11:30 p.m.

Discussion

Diagnosis is concerned with:

1. Type of original heart lesion. Owing to the patient's illness no efforts were made to study this in detail with exercise tests, posture, fluoroscope, etc. The rheumatic history, enlargement of the heart and loud systolic murmur suggested aortic stenosis of insufficient degree to give a thrill and probably a mitral incompetence.

2. Cause of the temperature. The history of tooth extraction at once suggested subacute bacterial endocarditis but as the temperature had only been present for 12 days and was associated with cough, influenzal or virus pneumonia and lung abscess had to be considered. As the X-ray only showed enlargement of the left ventricle and hilar congestion a pneumonia could be ruled out. Consequently blood cultures were taken and eventually a strip viridans was grown. Daily urinalysis showed no R.B.C.s. The patient was asked to report any tender spots in the fingers or toes and these were frequently examined, but no embolic spots or splinter haemorrhages were found. The fundi were also negative.

3. Cause of the fibrillation. Fibrillation appearing in a patient without advanced mitral disease or hyperthyroidism is most commonly due to coronary occlusion. In this case embolism was suspected. The pain was not typical in radiation and might have been due to a sudden stretching of the liver capsule. Electrocardiograph ST deviations suggested an anterior infarct but a second tracing would have been necessary to make the diagnosis definite. However, he died too soon.

4. Cause of death. With sudden onset of extreme dyspnoea, shock and tachycardia, death was due to a cardiac complication or pulmonary embolus. It could have been a paroxysmal ventricular tachycardia, except that the rate was irregular. Large pulmonary emboli are not expected in bacterial endocarditis. The most likely cause was a second coronary embolism.

Treatment

1. Prevention: This is the second case I have had in two years in which subacute bacterial endocarditis followed tooth extraction. The first case was a young man with a slight congenital heart lesion which caused no incapacity. He died by inches over a period of three months, as he was not lucky enough to have a coronary attack. **Every patient with congenital or rheumatic heart disease who consults a doctor should be warned of the danger of tooth extraction.** The teeth should be cared for every 6 months so that extraction is unnecessary. If an extraction is imperative, 45 grains of Dagenan should be given 3 hours before operation and the socket should be filled with sulfanilamide. A blood culture shortly after any tooth extraction is positive in a high percentage of cases. In normal persons this is a transitory harmless phenomenon but in patients with rheumatic or congenital heart disease the organisms in some cases will lodge on damaged endocardium. Patients with mild aortic or mitral incompetence are most vulnerable and it is rare in advanced mitral stenosis, fibrillation or congestive failure. Many cases of viridens endocarditis have no obvious cause such as a tooth extraction.

2. Treatment of the established infection is experimental and disheartening. One case whose vegetations were on the junction of an arteriovenous aneurysm of the neck was cured by removal of the aneurysm by Dr. McElmoyle last May. If this patient had not died of a coronary accident the plan was to test him clinically against various sulfanilamide compounds. The two most easy to take had already been found ineffective at the time of his death. Frequent small doses of mapharson would also have been tried. A combination of arsenicals and sulfanimides has been effective in a small percentage of cases. (Am. J. Med. Sc., Nov., 1940, p. 596.) One report claimed 9 recoveries in 45 cases for sulphapyridine combined with typhoid vaccine hyperthermia. (J.A.M.A., 1941, 1. p. 286.) —F.G.A.

Autopsy Summary

The body is that of a well built middle aged man of 40 years. There is no appearance of clubbing of the fingers, but the conjunctiva and extremities show marked pallor.

Thoracic Cavity

The pleura spaces are normal.

Right lung—650 gms. Left lung—990 gms. Both lungs are large and show fairly marked oedema throughout. There are no demonstrable infarcts present.

Heart—The pericardium is greatly increased in size extending practically into the axillary line. There is a considerable amount of sanguinous fluid in the sac and many shaggy fibrinous adhesions bind the visceral and parietal layers of the pericardium together. This is a very strik-

ing example of the "bread and butter" pericardium. The pericardium is thickened and extremely shaggy.

Heart markedly enlarged and weighs 1150 gms. The right auricle is normal. The tricuspid valve admits the tips of five fingers. The myocardium of the right ventricle is moderately thickened. The pulmonary valve is normal. The left auricle shows a roughened hemorrhagic patch which extends down to involve the auricular side of one of the mitral margins. Beneath this area, and between it and the aorta is soft hemorrhagic necrotic area 3 cms. in diameter. It is just above the upper border of the left ventricle. This area communicates with the left ventricle just below the aortic valve.

The mitral valve appears normal. The myocardium is firm and measures 22 mm. in thickness. The aortic valve is stenosed and markedly calcified. There are several very large friable vegetations present on the valve. The aorta shows minimal atheroma. The circumflex branch of the left coronary artery has a firm adherent recent blood clot occluding the first 2 cm. of its lumen. The remaining portions of the coronary vessels are soft and patent.

Abdominal Cavity

Liver—Large and weighs 3000 gms. It is normal in consistency and cut section shows a very slight amount of venous congestion or nutmeg appearance.

Spleen — The spleen is increased in size, weighing 410 gms. It is very soft in consistency.

Comment

Recent investigation shows that calcified aortic disease is of infectious origin usually rheumatic. The pericarditis is characteristic of rheumatic infection, likely an exacerbation. If it were due to a streptococcus polymorphonuclears would be present. The acute shaggy vegetations on the aortic valve with clumps of bacteria is a recent process on a previously diseased valve. The presence of the acute rheumatic pericarditis and acute aortic valvulitis due to streptococcus viridans is unusual.

Conclusion

Acute rheumatic pericarditis associated with acute aortic endocarditis (streptococcus viridans). —D.N.

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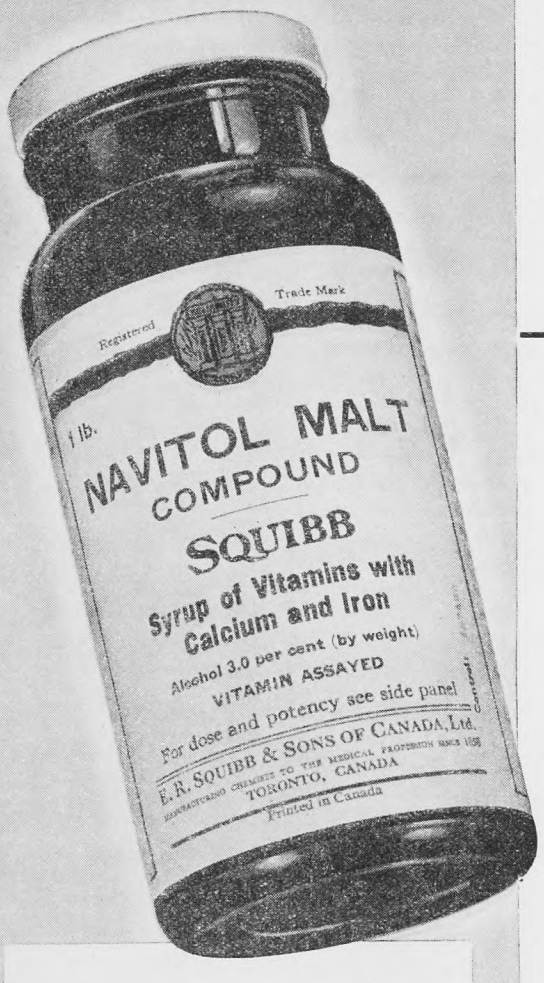

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*Suggested by National Research Council—not official.

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INDICATIONS

There are numerous instances where the diet is insufficient to meet the vitamin and mineral requirements of the patient and nutritional supplementation is advisable. There are other instances, where the diet is seemingly adequate in which malnutrition may occur as the result of interference with food intake, increased metabolism, malabsorption, malutilization, hastened destruction and excretion.

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Editorials and Association Notes

Manitoba Medical Review

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Abuse of Lugol's

The management of patients who have been unwisely Lugolised is an all too common problem. Either the diagnosis has been obscured by Lugol's solution in any dosage (or any other iodine compound including potassium iodide), or else a known hyperthyroid patient has been given Lugol's solution far in advance of operation, and the medication has lost its effect by the time surgery is possible. In the latter case the risk of operation is greatly increased.

The main legitimate use of Lugol's solution is its administration for ten days before operation, after the diagnosis is firmly established, and after the patient has agreed to submit to surgery. It is only common sense to leave this treatment to the surgeon responsible for the operation.

The other use of Lugol's is as a court of last resort in the differential diagnosis of a difficult case. Before it is used a careful written history should be prepared including reference to nervousness, palpitation, weight loss, appetite, bowel action, muscle power and heat intolerance. The examination should include eye signs, tremor, goitre, skin moisture and heat, pigmentation, waking and sleeping pulse rates on several occasions, and several observations of blood pressure. Helpful positive findings are a sleeping pulse rate, over 75, or a high pulse pressure. A very strong point against the diagnosis is cold moist hands and feet, particularly if bluish. The Basal Metabolic Rate should always be determined before Lugol's is given. It is stated that ten grains of quinine t.i.d. for one day will cause normal or hypothyroid patients to have slight tinnitus or deafness but will leave hyperthyroid patients unaffected. If the above conditions have been met and if operation is possible at the end of ten days, Lugol's may then be given as a therapeutic test, observing particularly its effect on weight, waking and sleeping pulse rates, B.P., heat intolerance and B.M.R.

It should be realized that the B.M.R., even when well done, is not an infallible answer to every case. Many conditions besides hyperthyroidism may increase it, and a patient with a high normal rate may actually have hyperthyroidism needing surgery.

The doctor who attempts to cure a hyperthyroid patient with Lugol's solution is wantonly risking his patient's life. —F.G.A.

Coma

(from the W. G. H. Internes' Hand Book)

Patients entering the hospital in coma are Emergencies. A life may depend on the rapidity with which a diagnosis is made and treatment instituted.

1. HISTORY—This is of paramount importance. If no friends accompany the patient, talk to the ambulance man. Then send out the police or social worker. Inquire especially about: type of onset, injury, alcohol, other poisons, infections, convulsions, headache, previous illness (diabetes, kidney trouble, high blood pressure).

2. PHYSICAL EXAMINATION— Be rapid and thorough. Remember this is essentially veterinary medicine. Your patient cannot help you. Use your eyes: note the patient's color, posture, movements; look for wounds, especially in the scalp. Examine the pupils, the eyegrounds, the eardrums, the throat. Use your nose: Is there an odour to the breath—alcohol, acetone, illuminating gas? Use your hands: Feel for a stiff neck, for fractures, for muscle and vasomotor tone in the extremities; for enlarged glands, palpate the abdomen, test the reflexes and Kernig's. Use your ears: Examine the heart and lungs. Take the temperature, pulse, respiration and blood pressure. Examine skin for needle punctures (morphine, insulin). Examine contents of pockets for syringe, medications or medical card.

3. ROENTGEN RAYS — Should be taken while the patient is on the way to the ward, unless the patient is in shock, when immediate shock treatment takes precedence over everything else. Skull plates should be taken on all injuries, and whenever the diagnosis is not evident. Other plates as indicated.

4. LABORATORY WORK — Gastric lavage for all poisonings, and severe alcoholics. Save the contents. 2. Catheterize and examine the urine as soon as possible. If reducing substances or acetone is present, and in all diabetics, do a blood sugar at once. 3. Do haemoglobin and smear. In the presence of infection take a blood culture. 4. Take blood routinely on nontraumatic cases for a Wesserman and non-protein nitrogen determinations. 5. Spectroscopy, electrocardiograph, Blood CO_2 combining power, etc., when indicated.

5. LUMBAR PUNCTURE— Routine in all injuries (except during shock), cerebral vascular accidents, convulsions, and meningeal irritation, and in all cases where the diagnosis is obscure. Note the initial pressure, colour of fluid, cell count and globulin. Remove enough fluid for Wasserman, total protein and mastic examination. When indicated, do smear, culture and chloride determinations.

In the presence of papilloedema permission to do a puncture must be obtained from a staff man. The puncture is then done with the manometer attached and the stop-cock handle turned away from the patient. When the first section of the manometer is filled with fluid the stop-cock handle is turned vertically to terminate the operation and let the manometer contents flow into the test tube.

The causes of coma in order of frequency:

1. Alcoholism, 59%.
2. Trauma, 13%.
3. Cerebral vascular lesions, 10%.
4. Poisoning (barbital or its derivatives, CO, bromides, $KMNO_4$, nitro benzene, lysol, sodium nitrite), 3%.
5. Epilepsy, 2.5%.
6. Diabetes, 2%.
7. Meningitis, 2%.
8. Pneumonia, 1.5%.
9. Cardiac decompensation, 1.5%.
10. C. N. S. Syphilis, 0.5%.
11. Uremia, 0.5%.
12. Eclampsia, 0.5%.
13. Miscellaneous (massive haemorrhage, burns, erysipelas, encephalitis, brain tumor, miliary tuberculosis, carcinomatosis, hypo glycemic shock, Stokes-Adams disease, immersion, syncope, hysteria, pernicious anemia, leukemia, ruptured ectopic pregnancy, intestinal obstruction, ruptured urethra, cholemia, empyema, septicemia), 4%.

The Manitoba Medical Service Plan

This plan has been devised after requests from various groups of employees for medical care on a prepayment basis. These requests came as a result of already established schemes such as the Winnipeg Firefighters Club, C.P.R. employees, C.N.R. employees, postal workers. Only the first of these schemes was open to the medical profession as a whole.

The Manitoba Medical Association assigned to its Committee on Economics the task of drawing up a scheme of voluntary health insurance in Manitoba. During 1941 the Committee on Economics spent much time in discussing various plans. In the fall of 1941 the Committee on Economics made a definite recommendation to the Manitoba Medical Association and this was approved by the Executive. On December 12, 1941, a meeting was held to which all Winnipeg practitioners had been invited and general approval was given to the two schemes presented, one giving complete medical care, the other surgical and obstetrical care in hospitals.

Provisional Board

A provisional board was appointed by the Manitoba Medical Association as follows: Doctors M. R. MacCharles (chairman), Brian Best, Hugh F. Cameron, J. S. McInnis, C. McRae, A. C. Abbott and Ross Mitchell. This group held several meetings. On February 7, 1942, a letter containing an outline of the two schemes and a tentative scale of fees was mailed to each physician in Greater Winnipeg with a request that within 24 hours the physician should signify his willingness, or the reverse, to enrol on the panel and to accept the stated fees.

Following this there were numerous meetings of this Committee together with Dr. H. D. Kitchen, President of the Manitoba Medical Association, the solicitor, Mr. W. C. Hamilton, K.C., and representatives of the Manitoba Hospital Service Association. After careful study it had been decided by the Committee that the Hospital Service Association, which has had such signal success, should act as agent of the Manitoba Medical Service in selling the plan and collecting dues. By-laws were drawn up, submitted to the closest scrutiny, and finally drafted. A joint meeting of the medical members of the Board of Manitoba Medical Service and the lay members, an exceptionally able group of business and labor men, was held and the by-laws were again considered. Copies of all these by-laws were mimeographed and sent to all the practitioners in Greater Winnipeg previous to a meeting of the general profession on October 30.

Agreement Finally Reached

At this meeting eight other doctors were chosen as a Law Amendments Committee: Drs. A. Hollenberg, W. G. Beaton, A. T. Gowron, J. M.

McEachern, C. G. Sheps, P. H. McNulty, C. M. Strong, and J. C. Hossack. This Committee has met with the previously named medical members of the Board of Manitoba Medical Service on several occasions. A letter under date of November 13 was sent out to all practitioners asking for criticisms, and these have been considered. Agreement has been reached and it is hoped that the scheme can be put into operation with the beginning of the new year.

A consequence of these delays, however, has been a cooling of interest on the part of some employee groups who are inclined to think that the medical profession is not genuinely concerned with any prepayment plan. A large firm has stated that it has become weary of the delays and has arranged with an insurance company to provide medical health insurance for all its employees.

The idea in the minds of the Committee on Economics was to devise a co-operative scheme which would benefit both the insured and the medical practitioners who were willing to go into the scheme. It is well known that there are smaller schemes open only to employees of certain companies and small groups of medical men. Manitoba Medical Service is open to all employees below a certain income level, now fixed at $2,400 per annum for married men, and $1,800 for single men, with medical care to be provided by any registered practitioner who wishes to become a medical member.

Advantages

One may ask what are the advantages of such a scheme.

For the employee it gives protection against the economic hazard arising from the type of illness likely to affect his standard of living. We are all acquainted with the advantages of insurance. Why should a man with a wife and young family be denied the privilege of protecting himself and his dependents against a catastrophic illness? He will be much easier in mind if he knows that medical care for himself and his dependents is provided for at a cost within his financial scope. The experience of the Winnipeg Firefighters Medical Scheme, now in its third year, is proof of this.

For the medical member it means a greater volume of work. The examination of recruits, of young people and of high school students has revealed an astonishing amount of physical unfitness, most of which is minor and easily remediable. For many, if not the majority of those examined, the cost of medical care under the old system has been prohibitive. With this barrier removed it is wholly probable that those disabled would seek relief. Also payment is assured, so that there is no necessity for haggling with patients over fees, or using the services of a collector or the courts to enforce payment.

It is admittedly an experiment, but it is an experiment which is being worked out in other provinces and in numerous States in the American republic. Surely physicians are not afraid of making a new venture. The Mayo Clinic at Rochester was a daring innovation when it was first started. One of the founders of a flourishing mutual insurance company was a medical practitioner in a small Manitoba town who for many years was president and general manager. Have initiative and co-operative enterprise disappeared from physicians of this day?

It is an open secret that the Dominion Government is considering a national scheme for health insurance. If Manitoba Medical Service can be put into effect with the new year, there will be experience gained which will be of the greatest benefit to the medical profession and the public.

Such a scheme as Manitoba Medical Service will aid our medical men who have been serving with the armed forces to re-establish themselves in practice after the war.

For the whole community there is the benefit of a co-operative enterprise without the element of profit. As patients are likely to seek relief earlier, there should be improvement in public health. It will tend to produce stability, a goal which is especially to be desired in the post-war period which is bound to be disturbed. No one wishes to see another general strike such as Winnipeg had in 1919. A community co-operative scheme like the Manitoba Medical Service will tend to prevent any such disaster.

If the proposed regulations and scale of fees are the stumbling blocks, it must be remembered that no plan can be proposed which will wholly satisfy all members of the profession. The regulations and the scale of fees are both tentative and can be modified as experience dictates. By-laws can be altered and added to meet unforeseen problems. Abandonment of the scheme should not be considered.

Ross Mitchell.

Post Graduate Course

The Post-graduate committee of the Faculty of Medicine has planned a refresher course designed for medical men in the services. The course will be held during the third week in February. Membership will be limited to medical officers of the armed forces. On Friday evening, February 19, a joint meeting of the Winnipeg Medical Society and those attending the refresher course will be held in the Physiology Theatre. A round table discussion on Peptic ulcer will be a feature of the programme.

Ambulance

The Winnipeg City Police ambulance will respond to emergency calls in the City of Winnipeg when no other ambulance service is available.

Obituaries

Dr. Thomas Alfred Martin Hughes died in Deer Lodge Hospital January 25 in his seventy-fifth year.

A veteran of the first Great War, he enlisted with the 128th Moose Jaw Battalion, and on his return from overseas in 1918 he practiced in Winnipeg until his death. He was born near London, Ont., graduated in medicine from Western University, London, in 1882, and came west about 1885. He practiced for many years at Souris before enlisting. He is survived by his widow, a son and daughter.

◈ ◈

After an illness of five years Dr. Frank M. Turner died at his home, 130 Monck Ave., Norwood, on January 24, aged 65.

Born at Albany, Ontario, he received his early education at Goderich, Ont., then attended Wesley College, Winnipeg, and University of Toronto, and returned to Winnipeg to graduate in medicine from Manitoba Medical College. After post-graduate work in New York and Boston, he practiced at Deloraine for three years and at Winnipeg and district until his illness. He is survived by his widow and a daughter.

Dr. Turner was an elder of Knox Church, Winnipeg, and a member of Northern Light Lodge, A.F. & A.M.

◈ ◈

Dr. James Thomas Adam Clarke died at his home in Winnipeg on January 23, aged 69. Born at Millbrook, Ont., he was educated at Queen's University, Kingston, where he took his Arts and part of his medical course. He graduated from Manitoba Medical College in 1901. For a time he practiced at Lauder, Man., then at Cypress River, before returning to Winnipeg.

He was a member of the board of directors of Victoria Hospital and was well known throughout the province. He is survived by two daughters.

Letter From Dr. Cox of B.M.A.

B.M.A. House, Tavistock Sq., W.C.1.

My dear Ross Mitchell: November, 1942

You will see how careful we are becoming about paper; every scrap is precious and really when one reflects that a great deal of it comes from cutting down your glorious forests one can't help thinking it is wasteful to treat paper "as a scrap of paper."

I was not only in at the birth of the "National Ophthalmic Treatment Board," but also thought it one of the best public services the B.M.A. had ever rendered to the community.

I have read all about your Annual Meeting at Jasper and it seems to have come off very well. What did you think of your own particular section?

I have just had a very cheery letter from Mrs. Harvey Smith. She was evidently very pleased that Harvey's portrait is now hanging in his "spiritual home," as it very properly should do, and she says she thinks it is a good portrait. I am so glad. Few men I have met left a greater impression on me of complete honesty of purpose and devotion to his profession, his country and his family.

Another good Canadian friend was lost when Birkett of Montreal passed on, full of honours and with a fairly good toll of years to his credit. I "fell for him" the first time I met him and we corresponded occasionally almost to the last. But I never realized what a big man he was professionally until I read the excellent Obituary in the C.M.J. And now Nicholls, another old friend is on the shelf, but not yet gone, thank goodness. I don't want to feel that all my friends with whom I have kept in touch in Canada are gone, but now there are only Bazin, and you, and Mrs. Harvey Smith and Nicholls. Routley I hear from occasionally, but he is too busy for much private correspondence. So mind you don't forget to write occasionally.

I am very lucky in my correspondents. Sir Henry Brackanbury, a great B.M.A. man, often wrote after he left London, and we had much in common—a love of books e.g. He left me a choice of anything in his library and I chose his edition of Macaulay in 12 volumes which I have thoroughly enjoyed re-reading. The essays are a perpetual joy. Then owing to the instigation of another very old friend, C. O. Hawthorne, F.R.C.P., and a distinguished B.M.A. man, I have recently re-read Boswell and found it more entrancing than ever, though it did make me feel a little less confident of Macaulay's judgment. He treats Boswell as a fool—an inspired fool, it is true—but I think he does much less than justice to a man who married subject and style perfectly. And he wasn't afraid to stick up to Johnson when he thought his idol was wrong or unjust, as he frequently was—and yet what a *man!*

What a grand thing it is that we old'uns have not only our precious memories but our books to console us for the loss of much we regret.

Well, I must not be too garrulous, so I close with my very best wishes for yourself, Mrs. Mitchell and family and may we see the end of this bloody business in 1943. Canada at any rate can be very proud of what she is doing.

Yours as usual,

ALFRED COX.

Winnipeg Medical Society

C. B. STEWART — *President*
C. M. STRONG — *Vice-President*
MEETINGS
Third Friday, each month

J. C. HOSSACK — *Past President*
DIGBY WHEELER — *Past President*
Next Meeting
February 19th

H. F. CAMERON — *Secretary*
A. T. GOWRON — *Treasurer*
MEETINGS
Start exactly at 8:15 p.m.

NOTICE BOARD

The month of January was distinguished by two things out of the ordinary. First we had an address by Brig. Chisholm on the Man Power situation, and, at the regular meeting, an address by an "Old Timer." There was a link between the two speakers. Both were standing on the cross-roads of today, but one was looking into the future; the other was looking back through the long vista of half a century.

Brig. Chisholm's job is to fit the right man to the right place—which is not always in the services. After all, the civilians have still to be looked after, especially the rural civilians, many of whom are enduring the medical privations of the pioneers. Brig. Chisholm told of the draining of rural practitioners to the cities, and left no doubt in the minds of his hearers as to his feelings towards those selfish migrants. He spoke of several things, but the essence of his address was a warning. He warned the profession against antagonizing the people. There is a loud demand for state medical care—a demand that will be granted. Unless the doctors do all in their power to win the goodwill of the people, the people will ignore the doctors when the health legislation comes to be enacted. One has only to listen to the radio discussions on health insurance to realize that the layman has no thought for the doctor except as a necessary part in the scheme.

Brig. Chisholm pointed out that already we are under government control to some extent, for no one can take a salaried position or move out of the country without the permission of the government. It is possible for our affairs to be still further controlled in little and in great ways. In union there is for us tremendous strength, but union we cannot have till every doctor is willing to set his prejudices aside and lend his whole strength to our associations. Those who remain out of the fold are already enjoying benefits which others have won for them. By remaining aloof they make it possible for every one—including themselves—to lose what we have gained. What is now a cloud no larger than a man's hand is shaping itself into a whirlwind, and against the coming storm, strong and complete union is our sole defense.

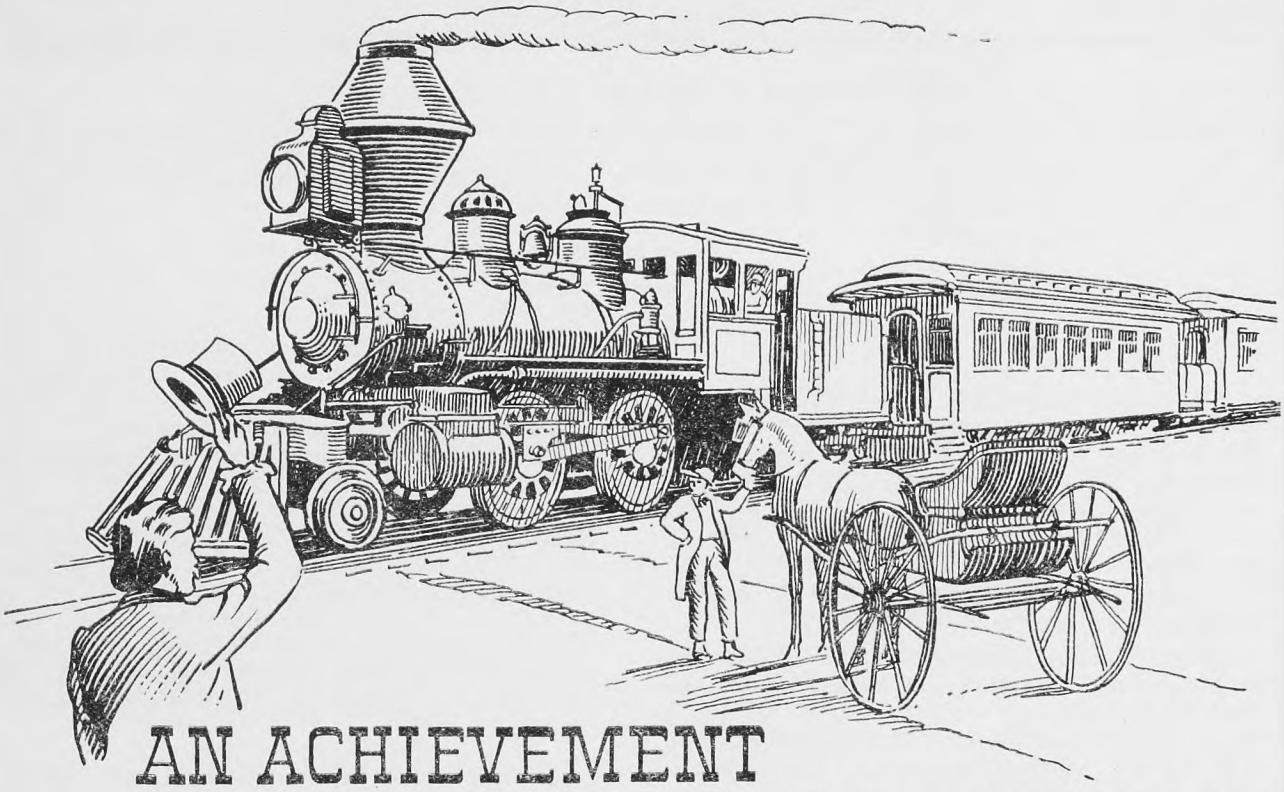
◈ ◈

More than seventy years of a busy life have neither dimmed the eye nor blunted the wit of Dr. Clingan of Virden—age cannot wither nor custom stale his infinite variety. He has been in practice for over 50 years—long enough to see medicine change from mysticism tinged with science to science tinged with mysticism. When he was a student surgery was antiseptic, "sterile preps" and rubber gloves unknown. Bacteria had arrived, he reminded us, but the "ologists" had still to come. The microscope was almost a curio. Even the stethoscope as introduced by Laennec was not of late date. X-ray was in its crudest form. Only the simplest laboratory tests were performed. The feverish sick were heaped high with blankets and no breath of fresh air allowed to touch them. Graves were opened every day for victims of diphtheria, typhoid and tuberculosis.

Through all the half-century of progress Dr. Clingan has kept pace with every advance. He has been prominent in many branches of medical effort in his district society, in the work of health officer. In addition he found time to go to France as a combatant officer and later to go to Parliament. In such a long and varied career there was much of interest and the many side glances he cast as he reviewed some of the incidents of his life were illuminated and amusing.

◈ ◈

Last month I appealed for contributions to the Overseas Fund. I am afraid that I'm not much of an appealer because only one cheque was received—for $5.00, from Dr. Thomas of Rivers. The matter, however, is of some urgency. This month we shall have to use the fees of about 50 members to send parcels to 80 members overseas. The Manitoba Medical is anxious to help, but cannot. The College of Physicians, which has between 40,000 and 50,000 dollars is prevented by law from contributing. The Society must therefore bear the load unless there are among you some who will help. John Crawford is in Hong Kong. Eddie Corrigan, Roy Rchardson and others to the number of about 80 are bearing the burden and heat of the day, several of them on the dangerous waters of the high seas. The revenues that once were theirs are now enjoyed by us. No day goes past I am sure, that we do not think of them, but they do not know that unless they get some tangible evidence of our thoughts. While this is addressed to the country practitioners I hope the urban doctors will not, if they read it, pass it by.



AN ACHIEVEMENT

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2. A gentle, thorough laxative with no danger of bowel irritation.

Pleasant to the taste. Especially effective for children, and wherever mild laxation is indicated.

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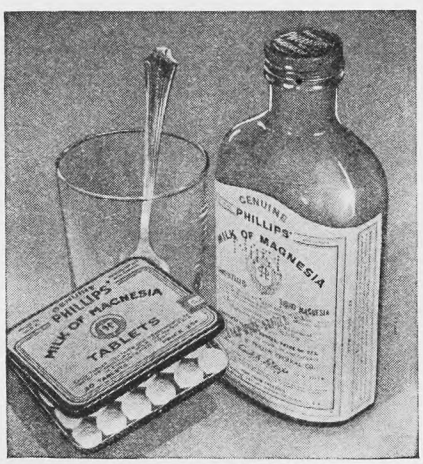
(2 to 4 Tablets)

As a gentle laxative: 4 to 8 teaspoonfuls.



PHILLIPS'
Milk of Magnesia

Prepared only by

THE CHAS. H. PHILLIPS CHEMICAL CO. Windsor, Ontario

Personal Notes and Social News

Dr. and Mrs. N. W. Warner, 54 Hargrave St., are receiving congratulations on the birth of a daughter (Mary Elizabeth), on January 15th at the Winnipeg General Hospital.

◈ ◈

Dr. H. M. Speechly was elected chairman of the Advisory Traffic Commission of the City of Winnipeg.

◈ ◈

Sir William Arbuthnot Lane, grand old man of British surgery, died at his home in London on Saturday, January 16th. He was 86 and it is said he campaigned for almost everything, including cleaner beer mugs in pubs.

◈ ◈

Dr. D. F. McCrea, formerly of Ninette Sanatorium is now attached to the Central T.B. Clinic, Winnipeg.

◈ ◈

Dr. S. M. Scott, formerly associated with the Cordite plant, is now with the Dept. of Pensions and National Health at Edmonton, Alta.

◈ ◈

Drs. D. J. Hastings, W. J. M. McFetridge, J. L. Downey, G. M. Stephens, H. L. Wylie, I. J. Lazareck and B. L. Rosenfield are now serving in His Majesty's Forces.

◈ ◈

Dr. R. Brodie Anderson, formerly with the Cordite plant, is now practicing in Winnipeg.

Dr. E. A. Jones, formerly associated with Dr. M. R. MacCharles, is now a Flight Lieutenant in the R.C.A.F.

◈ ◈

The Men in the Forces Need Magazines—Mrs. H. Douglas McLaughlin, chairman of the Imperial Order Daughters of the Empire magazine committee asks us to remember the need of reading material by dropping magazines in the bins on the street corners or phoning 24 181 for pick-up. These magazines go to the navy, army, air force and merchant marine.

◈ ◈

Flt. Lieut. and Mrs. David B. Stewart are receiving congratulations on the birth of a daughter (Elva Ruth) on January 13th, 1943, at the Winnipeg General Hospital.

◈ ◈

Dr. Magnus Hjalsson formerly of Winnipeg is now located in Glenboro, Man.

Oddities in the News

The following item appeared in a local newspaper January 19th: "Ottawa, Jan. 19th (CP)—The Canadian Medical Association siege of Leningrad and the capture of Schusselburg have properly put the wind up of both the Finns and Swedes according to reports reaching here." Spreading an epidemic of jitters is not in keeping with the oath of Hippocrates.

Department of Health and Public Welfare

The Prevention and Control of Typhoid Fever

by Maxwell Bowman, M.D.

Delving into the Statistical Records of Manitoba we find that in 1910 there were 174 deaths certified as due to typhoid* fever, in 1911, 117; in 1912, 136; 1913, 89; 1914, 66; 1915, 46; 1916, 43; 1917, 31. As the case fatality rate of typhoid holds steadily around 10% each of these deaths represents about ten cases. In 1918 reporting of cases was started—190 cases, 40 deaths—obviously not complete reporting of cases. In fact it was not until 1930 that case reporting became anywhere near on a par value with that of deaths. The deaths 1919 to 1940 inclusive were: 46, 49 ,43, 32, 30, 22, 23, 27, 27, 21, 28, 12, 15, 14, 17, 15, 12, 17, 10, 11, 16 and 18. The last two of these were 1939 and 1940 and epidemics had occurred in both years. In 1941 there were 41 cases reported and only one death; in 1942, 39 cases and three deaths.

This decrease in number of cases and deaths is marked and most gratifying. To what is it due? First of all to a safe chlorinated water supply in Winnipeg, St. Boniface and suburban municipalities, and in Brandon and Portage la Prairie. Second, to a better control of milk supplies and more use of pasteurization. Third, to some improvement in sanitation and personal hygiene, better reporting of cases and investigation and control of the sources of these.

Typhoid fever is a communicable disease and in nature attacks humans only. Therefore it should be controllable. The infection enters the body through the mouth and leaves mainly in the discharges from the bowel and kidneys, perhaps to a small degree in the sputum and other discharges. It is spread chiefly by indirect contact through water, ice, food (including milk and milk products), dishes, cutlery and fomites infected by the discharges from cases and carriers and to some extent by direct contact with cases and carriers. Flies, vermin and rodents may spread infection through contact with infected discharges.

It is quite evident then that typhoid is a disease due to faulty hygiene and sanitation. This gives us the key to prevention. Simple, isn't it?

We have seen above how the cities are taken care of, but have you visited one of the average or poorer than average rural homes in Manitoba? Did you take careful note of the well, its location, construction and protection against contamination? The privy, its construction, fly and rodent proofing, disinfection of contents, etc.? Is it used by all the men and hired help? If not, what provision is made for their sanitary requirements? Prevalence of flies in the kitchen, store rooms and dining-room? Provision for washing and bathing and proper disposal of bath and waste water? If you did, I am sure that you, with your knowledge of the spread of infection, were greatly disappointed in what you found! All that is needed to start an outbreak of typhoid in most of these homes is a visit from an ambulant case or careless carrier!

Why are such conditions allowed to exist? Properly constructed wells and privies cost money — so does their maintenance and repair. Money has not been too plentiful in rural areas, but perhaps **lack of education** regarding these health matters and **lack of interest** have been the chief obstacles. The answer given to questions as to why the well and privy are not properly constructed and maintained often is "They have been in the same condition for the past twenty to fifty years and we didn't get typhoid, so why should we now? If it's going to cost money we'll take a chance and leave it as it is!" The Department of health and Public Welfare distributes pamphlets, gives radio talks and some personal instruction **but** Health Education is a large problem. Some improvement in sanitation is taking place but not nearly enough to provide reasonable safety.

No Health Officer alone can eliminate typhoid fever from a city or community. It requires the help of all the doctors, nurses, sanitarians and the citizens themselves.

General Preventative Measures

(1) Safe and proper disposal of all human excreta.

(2) Education as to good personal hygiene. (If these two were perfect there would be no more typhoid.)

(3) Properly controlled, protected and chlorinated water supply.

(4) Use of pasteurized milk only, produced and handled in a clean manner. (Pasteurization may be done in a double boiler....

(5) Clean, protected, cooked food. Foods eaten raw require special protection from contamination (vegetables, shellfish, etc).

(6) Suppression or exclusion of flies, vermin and rodents.

Specific Preventative Measures

(1) Carriers to be controlled, supervised and instructed regarding hygiene and sanitation. They must not be allowed to act as cooks or food handlers.

(2) **Early diagnosis and immediate reporting of all cases and suspect cases to the proper authorities.**

(3) All cases and suspect cases to be isolated immediately, best in hospital.

(4) Inspection of home as soon as possible and instruction of residents as to hygiene, sanitation and disinfection.

(5) Vaccination of all contacts with T.A.B. vaccine. Also of all persons camping or going into areas where a safe water and food supply are not assured.

(6) Ascertain the source of all cases and take necessary steps regarding them as cases or carriers.

Under the Regulations of "The Public Health Act" it is the **duty** of every physician to report cases of Communicable Diseases to the Medical Officer of Health and pending his action to secure the isolation of the patient and to take such action as is required under the Regulations. It is also his duty to report deaths from Communicable Disease to the Minister. These are his duties, but as a physician he has a **responsibility** to his fellow-man that he use his knowledge to teach and instruct in order that hygiene and sanitation may be so improved as to prevent the spread of typhoid and similar infections. The Health Officer's duties are set out more specifically in the Regulations but if he does not receive the able, intelligent assistance of every physician his efforts cannot accomplish the ends desired.

The Department maintains on its staff an epidemiologist and qualified sanitary inspectors. These are available for your assistance at any time. A register of typhoid carriers is kept, also a register of every typhoid case reported in Manitoba since records have been kept. As every case is a possible carrier this register is of great value in indicating possible sources. (About 2% of all cases become chronic carriers.) No case should be released from isolation in the hospital or home before Laboratory tests on **two** specimens each of stool and urine, taken **one week apart**, are found negative for typhoid. This is a **minimum** — more weekly specimens are advisable.

Typhoid fever can be wiped out if every doctor, nurse and citizen makes it his or her business to assist the Health Officer in promoting the better understanding of Communicable Disease and its modes of spread, thereby assuring better hygiene and sanitation.

* in this article includes para-typhoid fever.

Efficiency Award

Winthrop Chemical Co. Inc. are extremely proud to announce that they have been awarded the U.S. Army and Navy Insignia "E" for efficiency in the production of Medical Specialties for the Allied Forces.

Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1942		1941		TOTALS	
	Dec. 3 to Dec. 31	Nov. 5 to Dec. 2	Dec. 3 to Dec. 31	Nov. 5 to Dec. 2	Jan. 1 to Dec. 31, 1942	Jan. 1 to Dec. 31, 1941
Anterior Poliomyelitis	2	3	4	1	65	1007
Chickenpox	396	266	356	249	2512	2229
Diphtheria	23	30	17	27	261	179
Diphtheria Carriers	1	7	7	7	39	27
Dysentery—Amoebic	.....	.....	.....	.....	.....	.....
Dysentery—Bacillary	.....	3	.....	.....	14	3
Erysipelas	2	9	7	6	91	75
Encephalitis	.....	2	1	4	40	515
Influenza	14	17	80	11	231	316
Measles	38	17	166	74	4401	3406
Measles—German	3	.....	12	16	263	1443
Meningococcal Meningitis	1	1	3	4	25	56
Mumps	267	136	210	196	3172	1447
Ophthalmia Neonatorum	.....	.....	1	.....	1	3
Pneumonia—Lobar	5	5	10	13	100	118
Puerperal Fever	.....	.....	1	.....	2	8
Scarlet Fever	47	68	91	75	1283	546
Septic Sore Throat	.....	1	4	2	59	19
Smallpox	.....	.....	.....	.....	.....	.....
Tetanus	.....	.....	.....	.....	3	1
Trachoma	.....	.....	1	1	5	8
Tuberculosis	26	57	93	52	571	599
Typhoid Fever	1	2	4	.....	34	33
Typhoid—Paratyphoid	.....	.....	.....	.....	3	1
Typhoid Fever Carriers	.....	2	.....	.....	3	1
Undulant Fever	.....	1	.....	2	11	5
Whooping Cough	117	123	23	35	693	288
Gonorrhoea	110	115	68	89	1257	1044
Syphilis	53	74	37	42	696	466

This period finishes the year 1942 so it is interesting to compare this year with 1941. It must be remembered that the figures for 1941 are complete but those for 1942 are only preliminary. Many late reported cases will be added.

POLIOMYELITIS—Did not reach epidemic proportions. Was this because the 1941 epidemic was so widespread that very few non-immunes were left to be infected.

DIPHTHERIA—Has increased in 1942—both in cases and carriers. Manitoba's report is much less favourable than that of Ontario, Saskatchewan, Minnesota and North Dakota.

BACILLARY DYSENTERY—Has been reported more than last year. We doubt that there has been any increase in cases.

ENCEPHALITIS—Only 40 cases but 17 of them died, a case fatality rate of 42.5 compared with 15.3 in 1941.

MENINGOCOCCAL MENINGITIS—In Manitoba is less than half the number in 1941. Ontario shows a higher four-weekly rate.

MUMPS—Have been epidemic in Manitoba.

OPTHALMIA NEONATORUM—Only one case reported in Manitoba in 1942!

PUERPERAL FEVER—Only two cases reported in Manitoba in 1942!

SCARLET FEVER and SEPTIC SORE THROAT— Both were more prevalent in 1942.

TUBERCULOSIS—No significant change. All open infectious cases should be confined in Sanitoria.

TYPHOID and PARATYPHOID—Again in 1942 we have been fortunate.

UNDULANT FEVER—More cases reported in 1942, probably many mild missed cases as well. What about pasteurization of all milk?

WHOOPING COUGH—Shows an increase over 1941.

SYPHILIS and GONORRHOEA—Both show an increase. This with Armed Forces and civilian travel was to be expected. Increased vigilance and effort will be required to control Venereal disease.

DEATHS FROM COMMUNICABLE DISEASE
November, 1942

URBAN—Cancer 48, Pneumonia Lobar 7, Pneumonia (other forms) 8, Syphilis 6, Influenza 3, Whooping Cough 2, Lethargic Encephalitis 1, Scarlet fever 1, Hodgkin's Disease 1. Other deaths under 1 year 15. Other deaths over 1 year 174. Stillbirths 11. Total 277.

RURAL—Cancer 44, Pneumonia Lobar 5, Pneumonia (other forms) 12, Tuberculosis 11, Influenza 3, Syphilis 3, Lethargic encephalitis 2, Septicemia 2, Diphtheria 1, Measles 1, Whooping Cough 1. Other deaths under 1 year 32. Other deaths over 1 year 238. Stillbirths 17. Total 372.

INDIANS—Tuberculosis 17, Pneumonia Lobar 1, Pneumonia (other forms) 16, Puerperal Septicemia 2, Dysentery 1, Chickenpox 1. Other deaths under 1 year 8. Other deaaths over 1 year 11. Total 57.

DISEASE	Manitoba Dec. 3-Dec. 31 *722,447	Ontario Nov. 29-Dec. 26 *3,752,000	Saskatchewan Nov. 29-Dec. 26 *949,000	Minnesota Nov. 29-Dec. 26 *2,792,300	North Dakota Nov. 29-Dec. 26 *641,935
Anterior Poliomyelitis	2	1	.....	2	1
Meningococcal Meningitis	1	16	2	1	.....
Chickenpox	396	1533	360	239	.....
Diphtheria	23	5	8	18	4
Dysentery Amoebic	.....	.....	.....	3	.....
Erysipelas	2	4	6	3	13
Influenza	14	1	.....	5	41
Leth. Encephalitis	.....	.....	1	.....	.....
Measles	38	513	213	22	3
German Measles	3	34	6	.....	.....
Mumps	267	2567	301	.....	10
Scarlet Fever	47	369	73	284	42
Septic Sore Throat	.....	1	.....	.....	.....
Tetanus	.....	1	.....	.....	.....
Trachoma	.....	.....	.....	.....	1
Tuberculosis	26	207	39	31	16
Typhoid Fever	1	2	.....	5	.....
Typhoid Para-Typhoid	.....	2	1	.....	.....
Undulant Fever	.....	2	.....	.....	2
Whooping Cough	117	370	20	191	61
Diphtheria Carrier	1	.....	.....	.....	.....
Gonorrhoea	†65	429	.....	.....	25
Syphilis	†42	426	.....	.....	26

*Approximate Populations.

†Dec. 3 to 23, 1942, only.

BOOKS WANTED FOR THE TROOPS

Books—fiction and readable non-fiction, and magazines will be received with pleasure by the Library Committee of M.D. 10. Ph. 24 181.